MISHAP REPORT

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

DATE OF REPORT:	TIME OF REPORT:	DATE & TIME OF INJURY / MISHAP:
NAME OF INJURED	FULL S.S.N.	NSAM - 61014 NPS - 62271. DEPARTMENT & UIC
CIV: MIL: NAF: JOB TITLE:	SEX: M F	RATE/RANK OR SERIES/GRADE
Date Hired:	DATE OF BIRTH: / /	Work Shift Hours:
SUPERVISOR NAME (PLEASE PRINT)	PHONE #	INJURED BODY PART

TYPE OF MISHAP: PERSONAL INJURY: PROPERTY DAMAGE: MOTORCYCLE:
PRIVATE VEHICLE: GOVERNMENT VEHICLE:

LOCATION OF MISHAP: ON BASE: OFF BASE: BLDG #: SPECIFIC LOCATION:

DESCRIBE THE NATURE OF INJURY / PROPERTY DAMAGE:

HOW OCCURRED:

CORRECTIVE ACTION/COMMENTS:

MEDICAL TREATMENT

	NO	YES	DATE	WHERE
PHYSICIAN OFFICE VISIT?				
HOSPITAL EMERGENCY ROOM VISIT?				
SELF-TREATMENT?				
LOST TIME EXPECTED?				# OF DAYS
LIGHT DUTY EXPECTED?				# OF DAYS
HOSPITIZATION?				# OF DAYS
DIAGNOSTIC PROCEDURES (X-RAYS, ETC.)?				
PRESCRIPTION STRENGTH MEDICATION?				
OVER THE COUNTER MEDICATION?				
WOUND COVERINGS (BANDAGES, ETC.)?				

DESCRIBE THE MEDICAL TREATMENT / FIRST AID:

SUPERVISOR'S SIGNATURE

Local Revision 12/2005